Exhibit 2

(contains Appendices A, B, C, D, E & F)

My Appeal ltr to IRS based on "Medical Waiver" & "Financial Disability".

Dated Feb 19, 2020

Exhibit 2

Donna F. Chu
Subramanian Subbiah
104 Elm St.
Menlo Park, CA 94025

IRS
P.O. Box 9005, Stop 614A
Holtsville, NY 11742

Feb 19, 2020

To whom this may concern:

Letter of Reference: #0161228170, dated Jan 21, 2020, LTR 105C 0
Tax Payer ID#: 135-66-8115
Kind of tax: Federal
Amount of claim: $52,271.72
Date of claims received: Oct. 11, 2019

1. Prepare a written statement that you want to appeal to the Office of Appeals.

I wish to appeal this rejection on the grounds of financial disability brought about by a medically inability to do any gainful work. After a series of severe heart attacks, and surviving death after prolonged novel stem cell trial treatment as world's first, complicated by diabetes, I finally was able in October 2019 (after the annual heart attacks stopped) to talk to the IRS about years of non-filing and approximately $50K a year federal tax overpayment (as evidenced by many years past tax refund history) and $10K state tax overpayment. They recommended that I file year end 2014 and year end 2015 anyway, despite technically exceeding the 3-year limit, and to appeal when the claim is automatically rejected, as it has now for the year end 2014 period. I filed both years, and followed with my state filings and had intended to file subsequent years until my health deteriorated again in past 2 months as explained later. But in past couple of weeks I have gotten better and have started work on the subsequent years and expect to have them in soon. In the mean time I received this claim-rejection from a Jennifer Gross of the Claim Campus at Brookhaven. I have answered most all of the questions below and attached suitable hospital discharge summaries of each of many severe life-threatening incidents over the past few years. (I have thousands more of hospital records if needed).

I realize I have to get a doctor's letter as well. It seems to me that the main letters you need are from the same doctors who treated me in the first two years that were the most serious and put me out of the 3-year window I am allowed. The first catastrophic incident was in rural Wisconsin, when I was travelling. I have all the voluminous hospital records (I attach some summary pages) and I am since trying to find the ER heart surgeon who

 Exhibit 2

seems to have moved around a lot. I have finally located his current whereabouts and trying to get a letter from him. The second doctor was the stem cell trial chief at Cedar Sinai in Beverly Hills, whose trial I was in for over a year and I have just got through to his new location and his nurse has agreed to get a letter for me. My current doctor of 3 years, the Stanford Chief cardiologist and President of the Interventional Cardiologists Association of USA, has promised to write about my later annual 3 separate follow-on heart attacks until about a year and a bit ago.

Since I do not have any of these letters yet and so I decided to ask for an extension by phone. I had tried to call the number given in the letter 866-897 0161 for a few days now and never managed to get past the menu to any human. I am still weak and tire easily. Eventually, with the looming 30 deadline to respond approaching (Feb 20 2020) I gave up and called the general IRS number. After over an hour and talking to 3 different IRS officials (First a man and then Ms. McMillan ID 1000778528) I finally reached John Labou (ID 1001677979) at exams. While researching my case, the call dropped and I had to start over at IRS general again and after another hour and a half (Mr. Drake ID 1001306133 and Ms. Meiia 1001793228) ended up back at exams talking to Ms. Gomez (ID 1001747506) who handed me to her supervisor Ms. Ballard (ID 1000199509). She spent a long time hunting and could not find any Jennifer Gross (Director) or the Brookhaven campus number. Eventually she like the others annotated my call-in record with their badge numbers and suggested that I should just fax it to tel. +1 855 240 6278 which she said was the nearest appropriate department "Audit Reconsiderations". So, I now am both faxing this note (without my doctor letters) and sending it by physical mail to the original address on the rejection letter in Holtsville to Jennifer Gross (director) of Campus Examination Brookhaven who wrote to me.

Please note while I send all this material, I am still asking for an extension, since I need to get my doctor's letters and a bit more additional evidence in (Summary of my 3rd heart attack and earlier diabetic ketoacidosis ER admission from Stanford).

I trust someone will call me at 650 431 6824 in California. Or write to me a phone n umber and a person I can actually reach – not a menu of information with no path to a human being.

The 4 hours on the phone has been extremely tiring and frustrating.

2. List the tax periods or years and disallowed items you disagree with and why you don't agree with each item.

Tax period: Dec 31, 2014
Disallowed items: Amount of claim: $52,271.72

Reason why we are appealing this disallowance: I, the husband, Subramanian Subbiah, experienced financial disability during at least Jan, 2014 to 2017 and beyond due to a

 Exhibit 2

medically-determined physical (possibly worst heart attack in USA the first year, followed by 1+ year novel stem cell clinical trial to escape death and then 3 years of annual heart attacks, involving a total of 8 stents and diabetic complications) that together resulted in a disability to manage financial matters. Especially in the first 2 years plus I had stage D heart failure with inability to engage in regular daily activities and/or to work on a sustained basis. So, I was unable to perform any type of gainful activity due to physical impairment. Only I and not my wife had knowledge of some of the important aspects of our joint filing relating to our stock portfolio, other private financial investments, and a prior attempt at starting a hi-tech start-up business that has since fizzled out during my illness. During this time my wife, Donn Chu, continued to work, take care of my two young kids and her own elderly parents who died one after another on the East Coast (we live in California) – her Dad at 100 and her mother at 88, after severe illnesses and multiple admissions to ER and long stays. And her work always deducted excessive tax withholding, typically annual refunds from IRS in the few tens of thousands od dollars (Federal) and ten thousand or so in California State tax, including in the year of dispute here – year ending Dec 31 2014.

3. Provide your name, address, taxpayer ID#, daytime telephone#, and a copy of this letter.

Donna Chu
Address: 104 Elm St, Menlo Park, CA 94025
Soc Security#: 135-66-8115
Daytime phone #: (650) 867 4813

Subramanian Subbiah
Address: 104 Elm St, Menlo Park, CA 94025
Soc Security#: 024-64-1852
Daytime phone #: (650) 431 6824

4. Include a detailed statement of facts with names, amounts, locations, etc., to support your reasons for disrupting the disallowance.

As described in (1) above, I miraculously survived a series of 4 heart attacks and 8 stents put in, while also suffering near diabetes complications, since 2013 to late 2019, when I first went over 12 months without a heart attack, while still weak. I state the events in chronological order and attach detailed hospital discharge and other summaries of each event (I have over few thousand pages of medical reports and records and I have included hospital summaries of a few main events, and waiting for Stanford Medical Center to send me the summaries for some others).

April 2012 – Sudden diabetes related ER admission, where I was minutes away from death from complications – severe end-stage diabetic ketoacidosis with astronomic glucose levels. After several days at Stanford Hospital ER I was released with severe insulin loss and diabetic. (hospital summary being sent to me by Stanford hospital).

Exhibit 2

April 2013 – Sudden heart attack while travelling near Milwaukee in rural Wisconsin. Was the worst heart attack in America that year. Troponin levels that were far higher at >150 than the threshold for a heart attack of >5. Levels were at > 3000 when >150 was already a big heart attack. Lost about half capacity (LVEF of 30+%. In fact 29% is considered by Social Security as automatic classification of being disabled for life without need to petition – and the level was expected to get worse and death in less than a year. Normal is 55% to 60%). The surgeon, the premier cardiologist in Wisconsin, did not have small enough stents for my artery size (Asian Indians are known to have small arteries). He made do with 2 poorly placed large ones and saved my life. (summary attached). Appendix A

May 2013 – Had two more elective stents put in paid to complete the emergency job at Cedar Sinai Hospital in Beverly Hills, California (the hospital that does more heart-lung transplants then anyone else, and the one credited with inventing the modem heart stent). My cardiologist was Raj Makkar, who has done more stents done anyone else and is now the head of their $1B new institute. (Summary attached) Appendix B

June 2013 – Recruited for a novel stem cell clinical trial to try to rescue dead muscles after severe heart attacks. Enrolled in first batch of 5 patients, with 2 placebo (I got real cells). At Cedar Sinai in Beverly Hills. The trial went for just over a year and with many long hospital stays and ups and downs. Dr. Maraban, had been chief cardiologist at Johns' Hopkins Hospital in Baltimore, before being recruited by Cedar Sinai at Beverly Hills to pursue the novel stem cell research since he did not have funds for under the Bush administration ban on stem cell research at John's Hopkins (regarded as best hospital in world), while California voters had approved a $10B voter initiated funding for stem cell research within California. (summary attached) Appendix C

June 2014 - At the end of the stem cell trial situation improved and LVEF ejection fraction was just below normal at 45% to 447% or so (normal is 55 to 60%). Enough to be up and walking but always weak. And any physical exertion, like running up steps or 3 minutes on treadmill would require me to be immediately admitted to ER for observation as my heart rhythm would go catastrophic indicating an imminent heart attack. Still I was the first patient to show this level of recovery, for any stem cell initiative for any disease, and Johnson and Johnson invested $300M in their program on the strength of this and I was asked to be a mascot for the state of California stem cell initiative that had exhausted much of the $10B and was and still is seeking additions billions from voters. Their effort is called American for Cures and I was a spokesperson sometimes. (the hospital summary attached). The link is www.americansforcures.org (Still waiting for Cedars Sinai to get me discharge summary).

September 2015 – Having been weak all year, I had a sudden heart attack and was admitted into Stanford ER and just as it started stented again by Dr. Alan Yeung, the Stanford chief cardiologist and then President of the American Association of

Exhibit 2

Interventional Cardiologists. My earlier hurriedly placed too-large stents were failing and needed shoring up. (Stanford summary attached). Appendix D

October 2016 – After some recovery had another heart attack, this time on the right side. Again, they caught it because, while I was doing my physical at Stanford, they had to emergency stop my treadmill after 2 minutes as that had triggered a heart attack. New stents were put in on the right side. Alan Yeung also operated. (I am waiting for Stanford medical records to send me summaries). Appendix E

October 2017 – After some relief, with again no physical exertion possible and constant headaches and general weakness, shortness of breath, I ended up with another heart attack, and 1% loss of muscle, no again on the right side, needing more stents. I had further ER complications the next week with severely swollen arm from the earlier cath/angio procedure (Stanford hospital summary attached) Appendix F

October 2019 – now after a year without my annual heart attacks, I began to feel better and was able to start looking into my tax matters. My wife too had just survived the passing of her mother, after her father as the eldest daughter, with an estranged son who had semi-disappeared. My twin children had reached high school age. I called IRS and they told me that technically year ended 2014 and year ended 2015 had passed since it was over 3 years, but I should file anyway and after I am likely rejected to then appeal, which is now what I am doing. I filed both years and still waiting to hear about the latter one. I had intended to file the following years but after filing the state ones for the same two years, I felt ill again with constant migraines and broke my teeth bridge (since being a hear patient and constant surgeries, dentists will not do any cleaning or rot maintenance since they worry about bleeding to death owing to blood thinners. So, I needed painful teeth implants that weakened me. I have since gotten better in past week or two and am working on the remaining years 2017, 2018 and 2019.

5. If you know the particular law or authority that supports your position, identify that law or authority by providing a legal citation.

   Financial Disability, backed by medical incapacity caused by continuous (more than 12 months) medical condition that could have anytime resulted in death (and even now). This was described in your letter of claim rejection to us where this was described as valid reason for an appeal. Also, this was discussed, in your Publication 556, Examination of Returns, Appeal Rights, and Claims for Refund.

6. Sign the perjury statement below and include it with your written appeal.

   Signed and attached.

Exhibit 2

7. Mail your written formal protest to the address at the top of the first page of this letter.

We mailed it to the address give at Holtsville PO Box 9005 – Stop 614A address. In addition we also faxed a copy of the same as here to +1 855 240 6278, a number given to us by Ms. Ballard IRS 1000199509 for "Audit Reconsideration" Division, since after much effort she could not find Jennifer Gross (Director) or her Department – Campus Examination Brookhaven" anywhere within her IRS database when we reached her as the 7th individual we explained to at IRS about the situation in past few days in trying to get through to the number given to call back on our letter – 866 897 0161. Jennifer Gross had signed off on the claim-rejection letter we received that mentioned this possibility of appeal.

Yours Truly,

Subramanian Subbiah

Exhibit 2

Appendix A

April 2013

Exhibit 2
Appendix A

SUBBIAH, SUBRAMANIAN; MR#: 419367; Acct#: 50259159; Arrival Date: 04/29/2013 18:15 CDT;Chart Status: Final

Wheaton Franciscan-Elmbrook Memorial Campus
19333 W. North Ave.
Brookfield WI 53045
262-785-2060

Discharge Report

Wheaton Franciscan Healthcare

Patient Name:	**SUBBIAH, SUBRAMANIAN**	**Sex:**	M
Birthdate:	10/29/1961	**Age:**	51
Acct No:	50259159	**Medical Rec No:**	419367
Arrival Date:	04/29/2013 18:15 CDT	**Visit Date:**	04/29/2013 18:22 CDT
Primary MD:	unknown		
		Attending MD:	Jerry Suriano DO
Chart Status:	Final		

Diagnosis

1) Chest pain
2) Acute myocardial infarction

First heart attack April 2013 Wisconsin

Tests

Non-MedOrder
CKMB
CK (Creatine Kinase)
ED-Pulse Oximetry Continuous
ED-Cardiac Monitoring
ED-Capped IV (Saline Lock) Second Access
ED-Capped IV (Saline Lock)
ED-O2 to Keep Sat > 92%
ED-POC Glucose
BNP (B Natriuretic Peptide) See comment for other Dx
BMP (Basic Metabolic Panel)
Hemogram with Differential
CK Total with CKMB
Troponin I
Magnesium (MG) Level
ED-Place Pacer/Defib Pads on Patient
XR Chest PA or AP Indication-Chest pain

Exhibit 2
Appendix A

WF - Elmbrook Memorial Campus Acct# 50259159 MRN: 419367
Patient: SUBBIAH,SUBRAMANIAN DOB: 10/29/1961 Provider: JOHN WYNSEN
Report: HISTORY AND PHYSICAL Doc Id: 9213221 Voice Id: 9822563
D. 04/29/2013 18:41 T. 04/30/2013 03:57

cc:

-- REPORT --

CARDIOLOGY HISTORY AND PHYSICAL

DATE OF ADMISSION: 04/29/2013

CHIEF COMPLAINT: Anterior wall ST segment elevation myocardial infarction of 60 minutes duration.

HPI: The patient is a 51-year-old male who has no known history of coronary disease. He states that 1 hour ago, he developed the onset of a chest discomfort radiating to his left arm. This persisted and he sought medical attention via an ambulance. He was brought to the Elmbrook emergency room. An ECG demonstrated ST segment elevation in the anterior leads with QS complex in leads V1, V2 and V3 and ST segment depression in leads III and aVF. He is in sinus rhythm. There is mild elevation in I and aVL as well. His pressure is currently 160 systolic. He is alert and oriented with ongoing discomfort. He has a Killip class I presentation. With regard to CAD risk factors, the patient states he has never used tobacco. There is no history of diabetes mellitus. He does have treated hypercholesterolemia and uses Lipitor 10 mg per day. He does not normally take aspirin, but was given aspirin today. He has an apparent strong family history of premature CAD in his parents. He does not have claudication. There is no history of CVA or TIA. There is no history of GI bleeding. His laboratories are not yet known. There is no history of atrial fibrillation. He believes his total cholesterol is in the 160 range. He has no allergies.

MEDICATIONS: Lipitor 10 mg per day.

ALLERGIES: None known.

PAST SURGICAL HISTORY: The patient had cranial surgery due to a car accident in the remote past was a scar on his forehead.

PAST MEDICAL HISTORY: Hyperlipidemia only.

REVIEW OF SYSTEMS:
GENERAL: No recent fevers, chills or cough. The patient denies visual difficulties. No unintended weight loss.
CARDIOVASCULAR: The patient denies any known history of CAD. He is quite physically active including very recently and did not have any chest discomfort. No history of CVA, TIA, claudication, rheumatic fever, PND, or orthopnea.
GI: Negative.
GU: Negative.
NEURO: Negative.
SKIN: Negative.

PHYSICAL EXAM:
VITAL SIGNS: Blood pressure 160/75, heart rate 71 and regular, temperature afebrile.

Exhibit 2
Appendix A

GENERAL: Pleasant, thin male in no distress.
HEENT: EOMI, sclerae are anicteric. Moist mucous membranes. No xanthelasma.
NECK: No bruits, normal upstrokes.
CHEST: Clear to percussion bilaterally.
CARDIOVASCULAR: Normal S1 and S2 without systolic or diastolic murmur noted.
ABDOMEN: Soft, benign, nontender, without hepatosplenomegaly. Nonpalpable aorta.

EXTREMITIES: No edema with normal distal pulses.
NEURO: Grossly intact. The patient is alert and oriented person, place, and time with normal mood and affect.

EKG: EKG reveals ST segment elevation in leads V1 through V4 with QS complex in V1 through V3. There is mild elevation in leads I and aVL with small Q waves present as well. The patient is in sinus rhythm with a normal PR interval. QRS duration is normal.

IMPRESSION: A 51-year-old male was seen with the following medical issues:
1. Acute anterior ST segment elevation myocardial infarction of just over 1 hour in duration. The discomfort is ongoing. He has a Killip class I presentation. He was given aspirin today.
2. Treated hyperlipidemia.

RECOMMENDATION: Urgent catheterization.

Authenticated and Edited by JOHN WYNSEN, MD On 4/30/13 6:10:17 AM

Exhibit 2
Appendix A

WF - Elmbrook Memorial Campus Acct# 50259159 MRN: 419367
Patient: SUBBIAH,SUBRAMANIAN DOB: 10/29/1961 Provider: JOHN WYNSEN
Report: CARDIOVASCULAR/ELECTROPHYSIOLOGY PROCEDURE Doc Id: 9213257 Voice Id: 9822654
D. 04/29/2013 20:29 T. 04/30/2013 05:55

CC:
JOHN C. WYNSEN, MD, Referring Physician

-- REPORT --

There is no primary care physician available. He is passing through town.

PROCEDURE:
1. Left heart catheterization.
2. Coronary angiography.
3. Left ventriculography.
4. Stent-supported angioplasty of a completely occluded proximal LAD with a 2.25 x 8, 2.25 x 26 and 2.25 x 12 Promus-element stents with minimal overlap, all postdilated with a 2.5 noncompliant balloon to 14 atmospheres.The most proximal stent abutted his L Main.

CONCLUSIONS:
1. Moderate distal left main lesion of 40-50%.
2. Complete occlusion of the very proximal LAD after S1 and D1 takeoff in the proximal L1 segment.
3. A 60- 70% proximal left circumflex lesion in a 2.25-mm vessel jeopardizing a second marginal distribution vessel. 60% mid M1 lesion.
4. Patent dominant RCA with only relatively mild irregularities.
5. Successful LAD stenting as noted above and below.
6. Left ventriculography reveals an akinetic distal anterolateral wall, dyskinetic apex and distal inferior wall with only the base of the heart contracting vigorously. There was mild mitral insufficiency and no gradient at pullback.
7. All L sided vessels were very small in caliber

TECHNIQUE: After informed consent with local lidocaine anesthesia, the patient's right common femoral artery was accessed using modified Seldinger technique. A 6-French sheath was placed and sequential use was made of a 6-French JL4 and JR4 catheter. Hand injections were made in left coronary system and right coronary artery in multiple angulated views. After quick brief angiography, a 3.5 EBU guiding catheter was placed into the left main and angioplasty/stenting procedure was performed of the LAD as dictated below. Left ventriculography was done in a 30-degree RAO view using 25 mL of contrast total. The sheath was sutured in place at the conclusion of the procedure.

DIAGNOSTIC ANGIOGRAPHIC FINDINGS:
LEFT MAIN: The left main was small in caliber as was the entire left system. The left main appeared to have moderate distal disease noted in particular in the RAO cranial view.

LAD: The LAD was completely occluded after 2 septals and a diagonal takeoff less than 15 mm from the takeoff of the LAD. The mid and distal LAD were not seen upon native injection. No collaterals noted.

Exhibit 2
Appendix A

LEFT CIRCUMFLEX: The left circumflex consisted of a nearly ramus vessel. This was a less than 2.5-mm vessel with mild to moderate irregularities including a 60% lesion in the midvessel. The proximal left circumflex had a 60-70% lesion in a 2.25-mm vessel at best. This jeopardized an M2 distribution vessel and a very small distal circumflex.

RCA: The RCA arose in the usual position.It had mild irregularities. There was a mild PDA lesion. No significant obstructive disease was noted.

PERCUTANEOUS INTERVENTION: A 3.5 EBU guiding catheter was placed into the left main. A short BMW wire was placed in the distal LAD. Initial predilatation was performed with a 2.0 balloon ultimately followed by placement of 2.25 x 12, 2.5 x 26 and 2.25 x 8 mm Promus element stents with minimal overlap. The entire segment was postdilated with a 2.5 noncompliant balloon to 14 atmospheres. Various diagonals were jailed, but not snowplowed. There was TIMI-3 flow restored.

MEDICATIONS: The patient received multiple aliquots of IC nitroglycerin through the left main guiding catheter. He received 500 mcg of Cardene through the left main guiding catheter. He received heparin at 80 units/kg bolus and double bolus Integrilin without an infusion. He received 60 mg of Effient at the conclusion of the procedure. He received aspirin in the emergency room.

DISPOSITION: The sheath was sutured in place. The patient's pressure was approximately 120 systolic at the end. His LVEDP was 20. He was in sinus rhythm with frequent idioventricular rhythm, "slow VT" which did not affect his hemodynamics.

He was taken to the ICU in stable condition with some residual chest discomfort poststenting, but hemodynamically stable.

Authenticated and Edited by JOHN WYNSEN, MD on 4/30/13 6:16:29 AM

Location	Pat. Name	Sex	Age	MRN	Admission Date	Facility	Acct. Number
DIS 05/04/13 15:00	SUBBIAH, SUBRAMANIAN	M	51 Y	419367	04/29/13 18:15	WFH-EM	50259159

Report for SUBBIAH, SUBRAMANIAN (MRN: 419367)

TEST: DISCHARGE SUMMARY
Collected Date & Time: 05/04/13 08:43

DISCHARGE SUMMARY

WF - Elmbrook Memorial Campus Acct# 50259159 MRN: 419367
Patient: SUBBIAH,SUBRAMANIAN DOB: 10/29/1961 Provider: JOHN WYNSEN
Report: DISCHARGE SUMMARY Doc Id: 9222686 Voice Id: 9834109
D. 05/04/2013 08:43 T. 05/06/2013 08:59

cc:

COPY

-- REPORT --

DATE OF ADMISSION: 04/29/2013

DATE OF DISCHARGE: 05/04/2013

DISCHARGE DIAGNOSES:
1. Large anterior wall myocardial infarction status post ostial/proximal left anterior descending on 04/29/2013 with residual significant left circumflex disease. CP to balloon time of 100 mins.
2. New postinfarction complete left bundle branch block with QRS duration of 158 ms and PR interval of 156 milliseconds. The patient had a narrow QRS complex at initial presentation. No evidence of AV block.
3. His peak CPK was 2957 with a peak troponin greater than 100.
4. Relative asymptomatic hypotension prolonging the patient's hospital stay and necessitating discontinuation of all cardioactive medications for the time being (Coreg/lisinopril and Aldactone).
5. Dyslipidemia with low lipoprotein(a).
6. Persistent fasting glucoses of over 140

PROCEDURES:
CATH: Emergent left heart catheterization on 04/29/2013 with placement of a 2.25 x 8, 2.25 x 26 and 2.25 x 12 Promus element stents from the ostial LAD going forward. These were postdilated with a 2.5 noncompliant balloon to 14 atmospheres. He had significant residual circumflex disease which was not addressed. His left system was very small in caliber. His LVEF was 35% with an akinetic LAD territory.

ECHO: LVEF of 35% and again severe LAD regional wall motion abnormalities. No apical thrombus was noted. No significant valve issues.

DISCHARGE MEDICATIONS:
1. Aspirin 325 mg per day.
2. Effient 10 mg per day.
3. Lipitor 40 mg per day (10 mg at admission)
4. Aldactone 25 mg per day-on hold.
5. Lisinopril 10 mg per day-on hold.
6. Carvedilol 6.25 mg b.i.d.-on hold.

Exhibit 2
Appendix A

HOSPITAL COURSE: The patient is a pleasant 51-year-old Professor of Biochemistry at Stanford University, who was in town for a regatta which his children were to participate in. He developed the acute onset of chest discomfort on the night of 04/29/13. He states he presented to Elmbrook Hospital within 30 minutes of the onset of discomfort. His ECG demonstrated hyperacute ST segment elevation in the anterior lateral leads. His CP to balloon time was ~ 100 mins. TIMI- 3 flow was restored, however, a large subsequent infarction ensued despite his early presentation. The patient states he was not known to be diabetic, however his fasting glucoses were persistently abnormal. On 05/03/2013 his fasting glucose was still 147. His creatinine was normal with a normal GFR. His peak CPK was approximately 3000 with troponins greater than 100. He remained in sinus rhythm throughout the hospital course. He developed relative hypotension after low dose beta blockers and ACE inhibitors were begun and these needed to be held for asymptomatic pressures as low as 85 systolic. On the day of discharge, his pressure was approximately 105 systolic after the medications had been held for 1 day. He was in sinus rhythm throughout the hospital course. He was 100% saturated on room air on the day of discharge. He had a low-grade temperature with negative blood cultures and a negative UA with no chest x-ray evidence of infiltrate. The low grade fever was ascribed to his large myocardial infarction. His white count on the day prior to discharge was 10,700 with a hemoglobin of 13.7 and a normal platelet count.

Lipids this hospital course revealed a total cholesterol of 189, triglycerides 192, HDL 39, and LDL of 111, with a non-HDL of 150. These were drawn the morning after his catheterization. A lipoprotein(a) was normal at 41 with an upper limit of normal of 75 for Quest Diagnostics Laboratory. A NMR LipoProfile was performed and this revealed a particle number of 1654. His particle size was large at 21.1 with an LDL of 124. His small LDL was 630.

The patient largely had an uncomplicated hospital course except for his asymptomatic hypotension. There were no issues with ventricular arrhythmias and there were no issues with overt heart failure. Once his cardioactive medications were held, his pressure appropriately rose. On the day of discharge, his BNP was 387.

He is to follow up with a cardiologistin Palo Alto quickly upon discharge with appropriate medications to be restarted as his blood pressure allows. His new cardiologist can make the determination as to whether circumflex stenting is appropriate. He did receive a DVD copy of his catheterization and appropriate copies of his cath dictation and laboratories etc.

Authenticated and Edited by JOHN WYNSEN, MD On 5/07/13 4:44:37 PM

Exhibit 2

Appendix B

May 2013

Exhibit 2
Appendix B

Subbiah, Subramanian (MR # 200581429)
D/C Summaries Signed by Ram, Vinny, MD at 5/17/2013 9:16 AM

Cosign Status:	Cosigned by Makkar, Rajendra, MD at 5/31/2013 1:32 PM
Version Status:	Signed

Interventional Cardiology Post Procedure/Discharge:

Admit: 5/15/2013
Discharge: 5/17/2013
Diagnosis: cad
Procedure(s): PCI of Circumflex and Ramus with Drug-eluting stents.
Condition: stable
Diet: cardiac
Dispo: home

May 2013
2 stents placed at Cedar Sinai to stabilize before stem cell trial

Subjective:
Overnight Events: None
Subjective: Feeling well, no complaints. No chest pain, SOB, lightheadedness. Ambulating without difficulty.

Objective:
EXAM:
BP 108/73 | Pulse 75 | Temp(Src) 97.8 °F (36.6 °C) (Oral) | Resp 16 | Ht 5' 6" (1.676 m) | Wt 150 lb (68.04 kg) | BMI 24.21 kg/m2 | SpO2 97%

General: no acute distress
Lungs: CTAB
Heart: RRR, no m/r/g
Abdomen: soft, nontender, nondistended. Normoactive bowel sounds.
Extremities: no groin swelling, minimal tenderness, soft no bruit, 2+ femoral pulse, 2+ distal pulses
Neuro: sensation and strength intact
Skin: no extremity discoloration

Labs:
Chemistry Panel:
Lab Results

Component	Value	Date
Sodium	139	5/16/2013
Potassium	4.6	5/16/2013
Chloride	105	5/16/2013
Carbon Dioxide	25	5/16/2013
Urea Nitrogen	15	5/16/2013
Creatinine	1.1	5/16/2013

CBC:
Lab Results

Component	Value	Date
WBC	9.2	5/16/2013
RBC	4.20	5/16/2013
Hemoglobin	12.9*	5/16/2013
Hematocrit	38.2	5/16/2013

Exhibit 2
Appendix B

Subbiah, Subramanian (MR # 200581429)
Platelet Count 241 5/16/2013

Tests:
Tele - no events

ECG -

Assessment and Hospital Course:

51 yo M with CAD with hx. Of PCI of LAD, s/p PCI of Circumflex and Ramus intermedius with Drug eluting stents.
benign hospital course overnight and discharged yesterday.

Plan:
Doing well. Ok to Discharge

1. **Continue home meds.**

2. **Continue Aspirin 81mg indefinitely and prasugrel 10mg minimum 1 year**

3. **Post-procedure activity restrictions:**
**Now: You may resume regular walking and going up stairs, may resume driving 24 hours post-procedure.
**For next 2 weeks:
1. Avoid heavy lifting (more than 15-20 lbs), straining/bearing down, squatting
2. No biking, swimming, or other activities with aggressive leg movements
**After 2 weeks: You may resume regular activity

4. **Contact your physician if you experience any of the following symptoms which may indicate a complication from the procedure:**
- redness, tenderness, or signs of infection (pain, swelling, redness, odor or green/yellow discharge around incision/access site)
- groin/extremity swelling or pain
- extremity numbness, weakness, or tingling in leg
- discolored or blue/black extremities

Also, contact your physician if you experience any of the following:
- temperature > 100.4
- persistent nausea and vomiting
- severe uncontrolled pain
- difficulty breathing, headache or visual disturbances
- hives
- persistent dizziness or light-headedness
- extreme fatigue

5. **May remove dressing once you get home. Keep area clean and dry, do not apply any creams or ointments. You may shower but no baths/pools/hot-tub for 1 week post-procedure.**

6. **Follow-up:**
-with your regular physician in the next 1 -2 weeks
-with Dr. Raj Makkar in the next 2-4 weeks. Call the office at 310-423-3977 to schedule an appointment.

Exhibit 2
Appendix B

Subbiah, Subramanian (MR # 200581429)
The above plan was discussed with Dr. Makkar who agrees with plan of care.

Vinny K.Ram, M.D.
Interventional Cardiology Fellow
5/17/2013, 9:11 AM

Exhibit 3

Appendix C

June 2013

Exhibit 2
Appendix C

CEDARS-SINAI
S. MARK TAPER FOUNDATION IMAGING CENTER

Cardiac MRI

Patient Name:	**Subbiah, Subramanian**	Referring Physician:	**Rajendra Makkar , M.D.**
Date of Study:	**2013-05-29** **Outpatient**		8700 Beverly Blvd., #6560
ID Number:	**200581429** Acct#:**29119212395**		Los Angeles, CA, 90048
Age: **51**	Sex: **M** DOB:**1961-10-29**		Fax (310) 423-0106 Phone (310) 423-3977

- Reason: assess myocardial viability, research study
- History: prior myocardial infarction (4/29/2013), multiple angiograms, multiple stent of the left anterior descending coronary artery, stent of the LCx
  ALLSTAR screening. Staged PTCA to ramus intermedius and proximal circumflex May 15. Prior PCI to LAD for acute anterior MI.
- Risk factors: hypercholesterolemia, diabetes, family history of coronary disease
- Medications: aspirin, HMG CoA reductase inhibitor
- Height: 66 in. Weight: 148 lbs. Body Mass Index (BMI): 23.9

June 2013

Begin/Recruited for Cedar Sinai Stem cell trial

MRI Scan Results:

- Gated MRI [rest gadolinium]
- **Myocardial Function:**

	LVEF	EDVi
Rest	34%	77 ml/m2

  Left ventricular wall motion demonstrated akinesis in the anterior, septal, inferior and apical walls.
- **LV Scar:** Definitely Abnormal (Transmural and subendocardial)

Vessel	**Extent**
LAD	large (anterior/septal/apical)

There are imaging features indicating a large prior LAD territory infarction that is transmural or near transumral in the interventricular septum (spares inferoseptum at the mid ventricular level), distal anterior wall and apex.
There is no apical thrombus seen. The LVEF is moderately decreased with the LVEF calculated as 34%.

Conclusion:

Status post LAD territory infarction with LVEF 34% on preliminary evaluation.
See attached images for DE showing the relatively large extent of myocardial enhancement.

Thank you for referring this patient to us.
Sincerely yours,

Louise Thomson M.B.Ch.B.

cc:Marban, Eduardo (Fax: (310)423-3522)

Electronically Signed: 2013-05-30 17:47

Exhibit 2
Appendix C

CEDARS-SINAI
S. MARK TAPER FOUNDATION IMAGING CENTER

Cardiac MRI

Patient Name:	**Subbiah, Subramanian**	Referring Physician:	**Rajendra Makkar , M.D.**
Date of Study:	**2013-05-29** **Outpatient**		8700 Beverly Blvd., #6560
ID Number:	**200581429** Acct#:**29119212395**		Los Angeles, CA, 90048
Age: **51**	Sex: **M** DOB:**1961-10-29**		Fax (310) 423-0106 Phone (310) 423-3977

Procedures:

Images were acquired in a 1.5 T Siemens Magnetom Avanto syngo scanner using ECG-gating and a phase array coil with IPAT and the use of Gadolinium contrast. Images obtained include delayed hyperenhancement, gradient echo cine, with gadolinium and with IPAT. Total gadolinium dose 26.0 ml.

Valves:

Mitral: Regurgitation: None **Tricuspid:** Regurgitation: None
Aortic: Regurgitation: None **Pulmonic:** Regurgitation: None

Pericardial:

Effusion: None **Thickness:** Normal
Enhancement: None

Measurements:

Left Atrial	4.4 x 3.4 cm	**LVEF**	34 %	**LV Mass**	88.0 g
Right Atrial	4.6 x 3.9 cm	**LVEDV**	135.0 ml		
LVEDD	5.3 cm	**LVESV**	88.0 ml		
LVESD	3.2 cm	**LSV**	46.0 ml		
		LCO	4.4 L/min		

Other Findings

Atrial Septal Defect	None	**Pulmonary Vein Anomaly**	Normal	**Left Atrial Thrombus**	Not Assessable
Aortic Disection	Not Assessable	**Pulmonary Emboli**	Not Assessable	**Pericardial Effusion**	None
Pericardial Thickness	Normal				

Louise Thomson M.B.Ch.B.

Exhibit 2
Appendix C

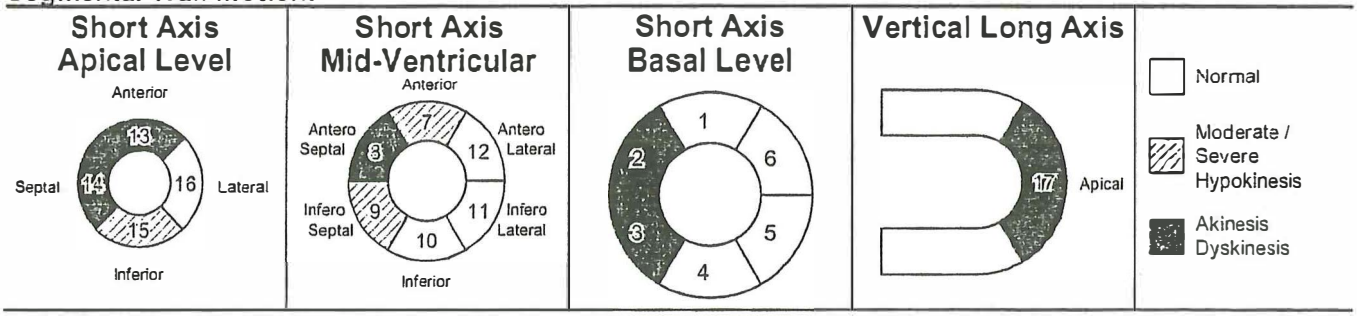
CEDARS-SINAI
S. MARK TAPER FOUNDATION IMAGING CENTER

Cardiac MRI

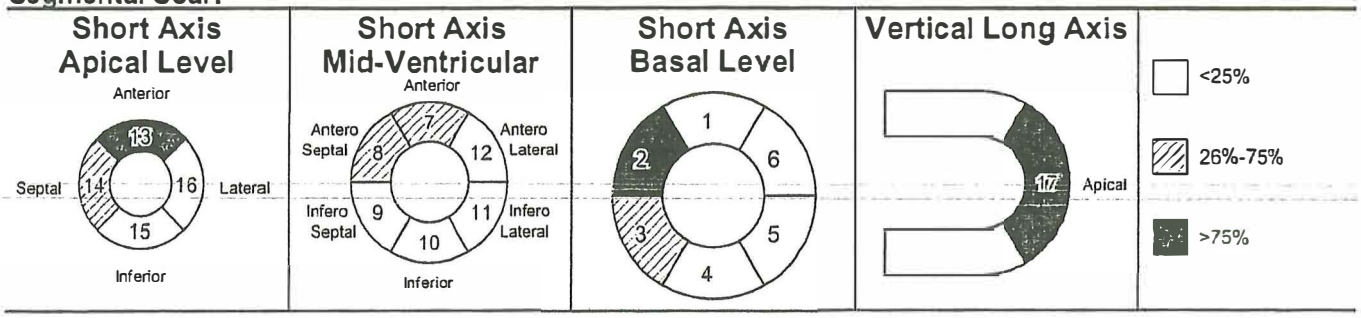
Patient Name: **Subbiah, Subramanian** Referring Physician: **Rajendra Makkar , M.D.**
Date of Study: **2013-05-29** **Outpatient**
ID Number: **200581429** Acct#:**29119212395**
Age: **51** Sex: **M** DOB:**1961-10-29**

8700 Beverly Blvd., #6560
Los Angeles, CA, 90048
Fax (310) 423-0106 Phone (310) 423-3977

Segmental Wall Motion:



Segmental Scar:



	R	SC		R	SC		R	SC		R	SC
13. Anterior	4	4	7. Anterior	2	2	1. Anterior	0	0			
			8. AnteroSeptal	4	3	2. AnteroSeptal	4	4			
14. Septal	4	3	9. InferoSeptal	3	1	3. InferoSeptal	4	3	17. Apical	4	4
15. Inferior	2	1	10. Inferior	0	1	4. Inferior	0	0			
			11. InferoLateral	0	0	5. InferoLateral	0	0			
16. Lateral	0	0	12. AnteroLateral	0	0	6. AnteroLateral	0	0			

WM: 0= Normal, 1= Mild Hypokinesis, 2= Moderate, 3= Severe, 4= Akinesis, 5= Dyskinesis
SCAR: 0= Normal, 1= 1-25%, 2= 26-50%, 3= 51-75%, 4= 76-100%
R = Rest SC = Scar

LV function Left ventricular wall motion demonstrated akinesis in the anterior, septal, inferior and apical walls.
LV Scar Definitely Abnormal (Transmural and subendocardial)

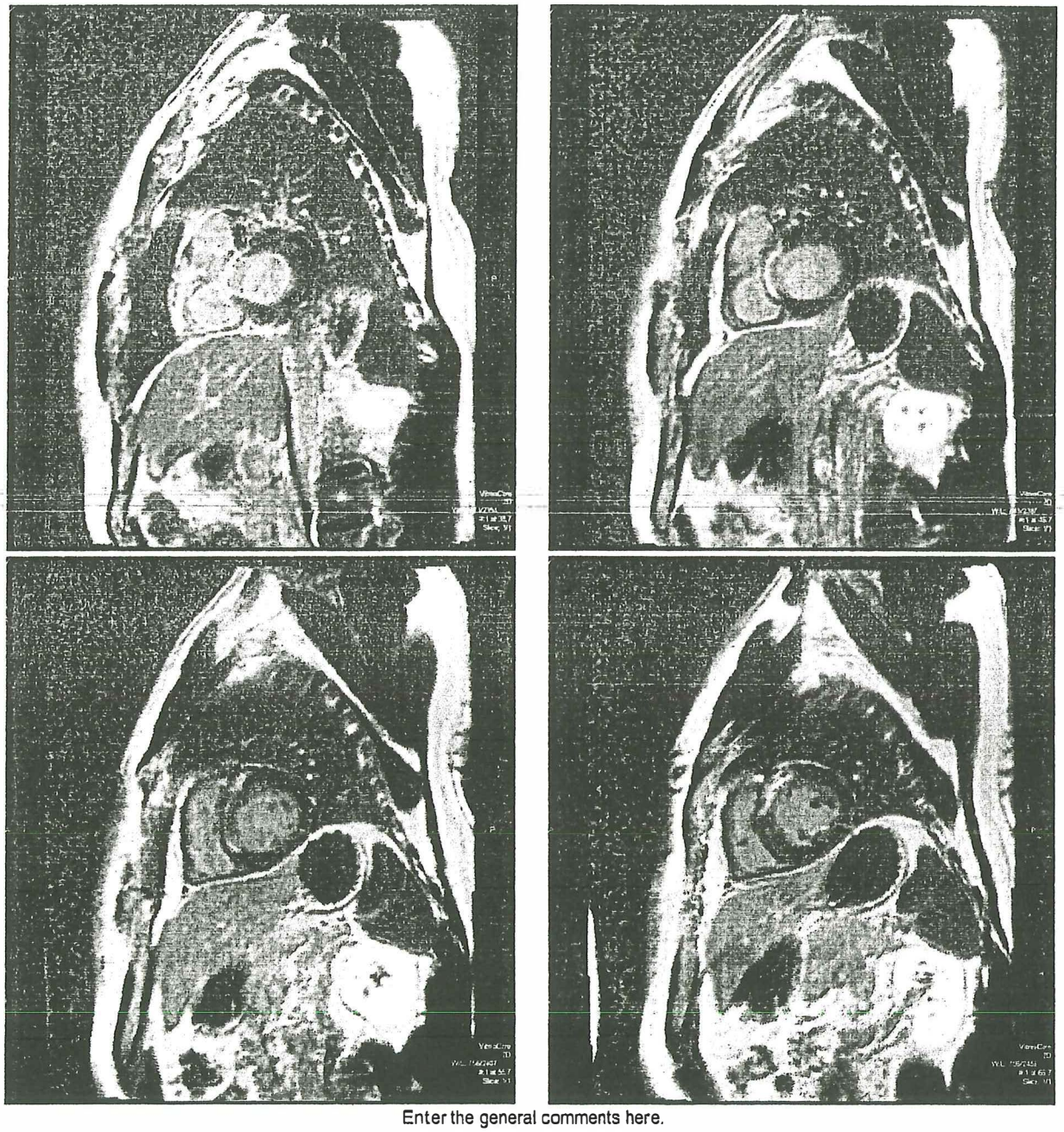
Vessel	Extent
LAD	large (anterior/septal/apical)

Louise Thomson M.B.Ch.B.

Exhibit 2
Appendix C

Cedars Sinai Medical Center

Patient ID: 200581429	**Referring Physician:** MAKKAR-V^RAJENDRA
Patient Name: SUBBIAH^SUBRAMANIAN	**Exam Type:** ALLSTAR RESEARCH^ALLSTAR RESEARCH
Date of Birth: 19611029	**Scan Date:** 20130529
Gender: M	**Report Date:** 2013.05.30-05:44PM

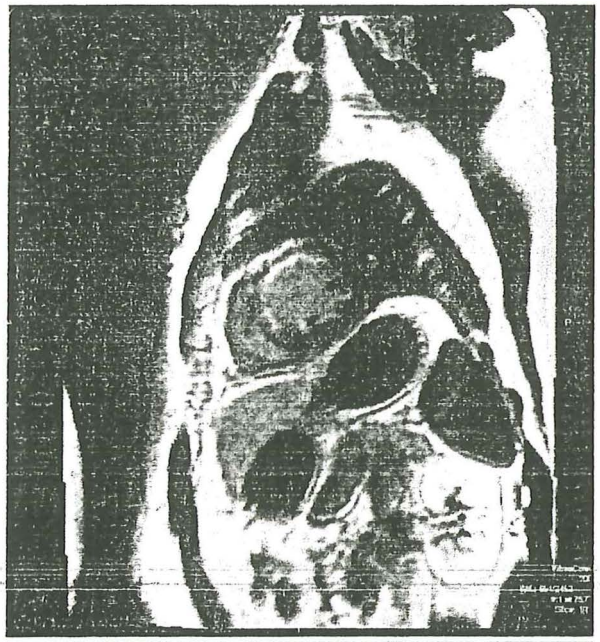


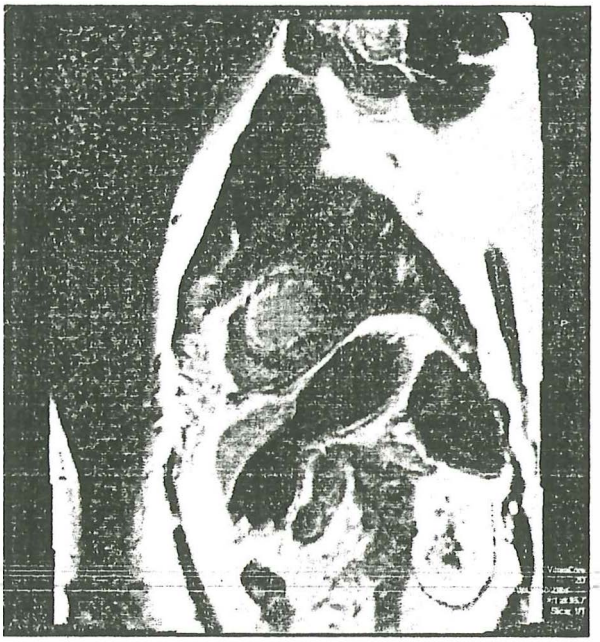
Enter the general comments here.

Exhibit 2
Appendix C

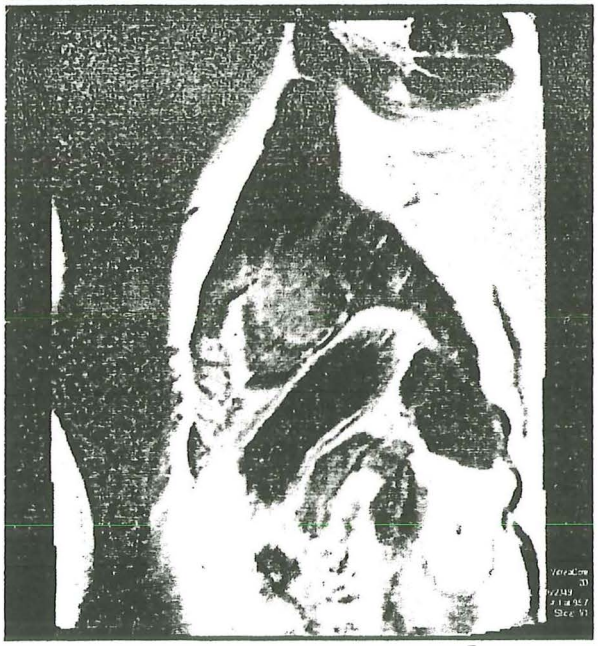
Cedars Sinai Medical Center

Patient ID: 200581429	**Referring Physician:** MAKKAR-V^RAJENDRA
Patient Name: SUBBIAH^SUBRAMANIAN	**Exam Type:** ALLSTAR RESEARCH^ALLSTAR RESEARCH
Date of Birth: 19611029	**Scan Date:** 20130529
Gender: M	**Report Date:** 2013.05.30-05:44PM





4



Enter the general comments here.

Exhibit 2

Appendix D

Sept 2015

Exhibit 2
Appendix D

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

ED Provider Notes by Yang, Samuel Sheng-E, MD at 9/1/2015 1:13 PM

Author: Yang, Samuel Sheng-E, MD | Service: Emergency Medicine | Author Type: Physician
Filed: 9/15/2015 1:54 PM | Date of Service: 9/1/2015 1:13 PM | Note Type: ED Provider Notes
Status: Addendum | Editor: Yang, Samuel Sheng-E, MD (Physician)
Related Notes: Original Note by Yang, Samuel Sheng-E, MD (Physician) filed at 9/3/2015 10:55 AM

(Stanford) Sept 2015
2nd heart attack

HPI

History of Present Illness/CC (use narrative or dot.edhpi for guide)
53 Y male with history of DM and CAD with prior MI in 2013 s/p 2 DES on 5/13/2015 and s/p intracoronary stem cell injection to LAD on 6/5/2013 presenting with four days intermittent chest pain.

The patient has mild stable angina at baseline since his MI with good exercise tolerance. However, in the last four days he found that walking 10 meters would make him SOB with chest pain. The morning of presentation to the ED he woke up with chest pain at rest, went to express care for prompt evaluation, and was referred to the Stanford ED. His last echo was 5/2014 with EF 50% with hypokinesis of apical cap.

Patient complains of left sided chest pain that radiates to both arms, 7/10 chest pressure at rest, nausea, denies diaphoresis and neurologic deficits (vision changes, numbness, tingling). The patient took 2 ASA 81mg this morning. He does not have NTG at home and has never taken it.

EKG x2 showed 1 mm ST seg elevation in V2 only.
Trop 0.00 x1
ASA 162 mg given
Sublingual NTG 0.4 given
Cath angio notified of patient
General cards consulted and admitted for progression of stable angina to unstable angina

Past Medical History

Diagnosis	Date
• Elevated cholesterol	
• PPD positive *no INH per pulmonary clinic*	1999
• Malaria *severe, with hepatic involvement*	1988
• Vitiligo	
• Tinea	
• Closed fracture of pelvic rim *MVA*	
• MI (myocardial infarction) *s/p DES to LAD*	
• Hyperlipidemia	
• H/O colonoscopy with polypectomy *5/2015 ,rpt 5 years, John Selling MD, tubular adenoma, repeat in 5 years.*	5/7/2015

Patient Active Problem List

Diagnosis	Code
• Hyperlipidemia	272.4

Exhibit 2
Appendix D

Official Copy
Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

ED Provider Notes by Yang, Samuel Sheng-E, MD at 9/1/2015 1:13 PM (continued)

• Malaria	084.6
• Vitiligo	709.01
• Pelvic Fracture	808.8
• Spinal Fracture	805.8
• Pain in Joint, Lower Leg	719.46
• Multiple open pelvic fractures with disruption of pelvic circle	808.53
• Keloid scar	701.4
• Hyperglycemia	790.29
• Hyperosmolarity due to secondary diabetes	249.20
• Hypernatremia	276.0
• H/O colonoscopy with polypectomy	V45.89, V12.72
• Diverticulosis of colon (without mention of hemorrhage)	562.10

Past Surgical History

Procedure	Laterality	Date
• Hx wisdom teeth extraction *times 4*		1988
• Colonoscopy *TA, repeat in 5/2020*		6/11,5/2015

History

Social History

• Marital Status:	Married
Spouse Name:	N/A
Number of Children:	N/A
• Years of Education:	N/A

Occupational History
- Not on file.

Social History Main Topics

• Smoking status:	Never Smoker
• Smokeless tobacco:	Never Used
• Alcohol Use:	No
• Drug Use:	No
• Sexual Activity:	Not on file

Other Topics	Concern
• Not on file	

Social History Narrative

Current Outpatient Rx

Name	Route	Sig	Dispense	Refill

Exhibit 2
Appendix D

Official Copy

Stanford HEALTH CARE STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

ED Provider Notes by Yang, Samuel Sheng-E, MD at 9/1/2015 1:13 PM (continued)

• aspirin 81 mg enteric coated tablet	Oral	take 81 mg by mouth daily.		
• atorvastatin (LIPITOR) 40 mg tablet	Oral	take 1 Tab by mouth daily	90 Tab	3
• Blood Sugar Diagnostic (ACCU-CHEK AVIVA) STRP	Misc.(Non-Drug; Combo Route)	1 Each by Misc.(Non-Drug; Combo Route) route 3 times a day before meals.	100 Strip	3
• lisinopril (PRINIVIL, ZESTRIL) 5 mg tablet		TAKE ONE-HALF (1/2) TABLET DAILY	90 Tab	1
• METFORMIN HCL (METFORMIN PO)	Oral	take 250-500 mg by mouth daily as needed		
• nitroglycerin (NITROSTAT) 0.4 mg sublingual tablet	Sublingual	place 0.4 mg under the tongue and let dissolve as needed. (Nitrostat only, do not substitute)		
• prasugrel (EFFIENT) 10 mg TABS	Oral	take 1 Tab by mouth Every Day	90 Tab	3
• ULTRA THIN LANCETS (ACCU-CHEK MULTICLIX LANCET) 33 gauge MISC	Misc.(Non-Drug; Combo Route)	1 Container by Misc.(Non-Drug; Combo Route) route 3 times a day before meals.	3 box	3

No Known Allergies

Review of Systems
Constitutional: Positive for activity change. Negative for fever, chills, diaphoresis and fatigue.
HENT: Negative.
Respiratory: Positive for chest tightness and shortness of breath.
Cardiovascular: Positive for chest pain and palpitations. Negative for leg swelling.
Gastrointestinal: Positive for nausea. Negative for vomiting, abdominal pain, diarrhea, constipation and abdominal distention.
Genitourinary: Negative.
Musculoskeletal:
Pain radiates to shoulders
Psychiatric/Behavioral: The patient is nervous/anxious and is hyperactive.
Appears manic, tangential, flight of ideas

Exhibit 2
Appendix D

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

ED Provider Notes by Yang, Samuel Sheng-E, MD at 9/1/2015 1:13 PM (continued)

Physical Exam

Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished.
HENT:
Head: Normocephalic and atraumatic.
Eyes: Pupils are equal, round, and reactive to light.
Neck: Normal range of motion.
Cardiovascular: Normal rate, regular rhythm, normal heart sounds and intact distal pulses. Exam reveals no friction rub.
No murmur heard.
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal. There is no tenderness.
Musculoskeletal: Normal range of motion.
Neurological: He is alert and oriented to person, place, and time. He exhibits normal muscle tone.
Skin: Skin is warm and dry.
Nursing note and vitals reviewed.

Procedures

MEDICAL DECISION MAKING

Initial impression

Subramanian Subbiah is a 53 Y male with chief concern of chest pain

Initial Ddx, assessment and plan:
Ddx includes but not limited to: unstable angina, NSTEMI, STEMI
Initial assessment & plan:
Troponin
EKG
Sublingual NTG
ASA 162 mg
CBC
CMP
Lipase
coags
NT-proBNP
Utox
Urinalysis
Lactate

Work up and therapy ordered in this encounter:

Orders Placed This Encounter

- XR Chest 2V
- Rainbow Draw (for ED/RRT/Code Blue only)
- CBC With Diff
- Prothrombin Time
- PTT Partial Thromboplastin Time
- Metabolic Panel, Comprehensive
- Lipase
- NT-ProBNP
- Urinalysis, Screen for Culture (Clean Catch)

Exhibit 2
Appendix D

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

ED Provider Notes by Yang, Samuel Sheng-E, MD at 9/1/2015 1:13 PM (continued)

- Drugs Of Abuse Screen, Urine
- iSTAT Troponin I
- iSTAT Troponin I
- iSTAT Venous Blood Gases And Lactate
- ECG 12-Lead
- ECG 12-Lead
- acetaminophen (TYLENOL) tablet 1,000 mg
- nitroglycerin (NITROSTAT) sublingual tablet 0.4 mg
- aspirin tablet 325 mg

Data reviewed and interpretation:
Trop negative x1
EKG possible ST seg elevation in V2
NT-proBNP wnl
coags wnl
Lipase 228
CBC wnl
CMP, glucose 146, Hgb A1c 6.7,
Lactate 1.02

Consults/referrals
Consults: CONSULT TO CARDIOLOGY INTERVENTIONAL-AMI
Consult summary: admit to general cardiology

ED progress
Cards admission

Most recent VS: BP 158/79 mmHg | Pulse 75 | Temp(Src) 36.7 °C (98.1 °F) (Oral) | Resp 16 | SpO2 100%

Final thought process
Summary of assessment: known CAD with hx concerning for UA. Trop negative. Admit to cards for further evaluation.

Diagnosis: Data Unavailable
Disposition: Data Unavailable Follow up: No follow-up provider specified.

New Prescriptions
No medications on file

Resident:
Attending: Samuel S Yang, MD

Attending attestation
I saw and examined the patient and discussed management with the resident.
I reviewed the resident note and agree with the documented findings and plan of care (except as noted in my own note).
I have reviewed the nurses / residents note regarding the patient's past medical, social and family history, as well as the nurses notes, medication list and allergies.

Samuel Yang, MD
9/1/2015
2:00 PM

Exhibit 2
Appendix D

ED Provider Notes by Yang, Samuel Sheng-E, MD at 9/1/2015 1:13 PM (continued)

Electronically signed by Yang, Samuel Sheng-E, MD at 9/15/2015 1:54 PM

Discharge Summary by Rogers, Ian Schirra, MD at 9/4/2015 5:39 PM

Author: Rogers, Ian Schirra, MD	Service: Cardiology	Author Type: Physician
Filed: 9/16/2015 10:11 PM	Date of Service: 9/4/2015 5:39 PM	Note Type: Discharge Summary
Status: Addendum	Editor: Rogers, Ian Schirra, MD (Physician)	

Related Notes: Original Note by Ferguson, Jessica Diane, MD (Fellow) filed at 9/6/2015 4:22 PM

Stanford Hospital and Clinics
Discharge Summary

Attending Physician: Ian Rogers MD
Attending Physician Contact Info: Stanford Hospital page operator at 650-723-4000 and page Ian Rogers MD
Additional discharging providers (NP, PA, intern, resident, fellow): Jessica Diane Ferguson, MD
Discharging service:
Admission Date: 9/1/2015
Discharge Date: 9/3/2015

Principle Diagnosis at Discharge: Chest pain

Patient ID: Subramanian Subbiah is a 53 Y male with hx DM and CAD with prior MI in 2013 s/p 2xDES to ramus intermedius and pCx on 5/15/2013 and s/p intracoronary stem cell injection to LAD on 6/5/2013 presenting with four days intermittent chest pain.

Reason for Hospitalization: Unstable Angina

Brief History of present illness:
Patient of Dr. Fearon's and last seen by him 3/2015. He reports he has had stable angina for the past two years with mild substernal chest pain ("pressure-like") with exertion. However, the past four days he has had 3-4/10 chest pain, occuring both at rest and with exertion. He now is only able to walk approximately 10 meters without having chest pain. The pain is a substernal chest pressure, radiates to bilateral shoulders, associated shortness of breath, similar but less severe than his prior MI. Denies nausea/vomiting and diaphoresis. The morning of admission he developed chest pain again upon awaking. He called his cardiologist, Dr. Makkar, at Cedars Sinai and was planning to fly to Los Angeles to have a repeat cardiac cath but then decided he should go straight to the Stanford ED to be evaluated.

Hospital Course/Significant Findings by Problem:

 # Unstable Angina - Pain improved with NTG 0.4 mg x3 and 1 mg IV morphine x1. He was given 162 mg aspirin and started on a heparin drip in the ED and continued on his home dose of prasugrel. Cardiac catheterization revealed 99% distal RCA occlusion and a DES was placed. Patient noted significant relief of chest pain post-stent placement and was discharged on 9/3/2015.
- continue aspirin 81mg daily

Exhibit 2
Appendix D

- increased atorvastatin to 80mg daily
- continue prasugrel 10 mg daily
- continue lisinopril 2.5 mg daily
- follow up with Dr. Fearon in 1 month

 # Diabetes Mellitus: Hgb A1c 6.7 (9/1/2015)
- resume home dose metformin 2 days after catheterization

Pertinent studies:
EKG 9/1/2015: normal sinus rhythm, slight J-point elevation V2 and V3, no ST or T wave changes

CXR 9/1/2015: Normal radiographic examination of the chest.

ECHO 9/2/2015:
1. Normal LV size with moderate systolic dysfunction. The estimated EF by MOD is 42%. There is akinesis of the
distal septum to apex as well as inferoseptal wall. Posterolateral hypokinesis.
2. Trace MR/TR.
3. No prior study for comparison.

Labs and Imaging Pending At Discharge: None

Procedures Performed (include dates):

Cardiac Cath 9/2/2015:
1) Right dominant coronary artery circulation
2) 1-vessel CAD (99% distal RCA; 50% ISR in prox-mid LAD stent; both new findings compared to prior angiogram)
3) Proceed with PCI to RCA

LM - no significant stenoses
LAD - 50% ISR in prox-mid LAD stent
LCx - previously placed stents in proximal LCx/OM1 are patent
RCA - 99% stenosis in distal RCA at take-off of r-PDA
Ramus - previously placed stent in proximal ramus is patent

Complications: None

BEST PRACTICE for patients with AMI or Heart Failure: No applicable diagnoses.
Code status during admission and details of discussions: Full Code
POLST form has been completed if patient discharged to SNF
Overall goals of care for patient's health and functional status: improve independence and functional abilities
Caregiver status: self
Functional status at time of discharge: Improved, stable

Disposition: Home
If other than home: Name of facility: Not applicable

Exhibit 2
Appendix D

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

Discharge Summary by Rogers, Ian Schirra, MD at 9/4/2015 5:39 PM (continued)

Emergency Contact: Extended Emergency Contact Information
Primary Emergency Contact: CHU,DONNA
Address: 104 Elm St
Menlo Park, CA 94025-2809 United States of America
Home Phone: 650-322-6505
Mobile Phone: 650-867-4813
Relation: Wife
Secondary Emergency Contact: CHU,DONNA
Address: 104 Elm St
Menlo Park, CA 94025-2809 United States of America
Home Phone: 650-322-6505
Mobile Phone: 650-857-4813
Relation: Wife

Allergies: No Known Allergies

Discharge Medications
Consent form attached for all patients on psychoactive medications discharged to SNF

What to do with your medications

TAKE these medications

	Instructions
ACCU-CHEK AVIVA Strp Generic drug: Blood Sugar Diagnostic	1 Each by Misc.(Non-Drug; Combo Route) route 3 times a day before meals.
ACCU-CHEK MULTICLIX LANCET 33 gauge Misc Generic drug: ULTRA THIN LANCETS	1 Container by Misc.(Non-Drug; Combo Route) route 3 times a day before meals.
aspirin 81 mg enteric coated tablet	take 81 mg by mouth daily.
atorvastatin 80 mg tablet Changes: - **medication strength** - **how much to take** Commonly known as: LIPITOR	take 1 Tab by mouth daily
EFFIENT 10 mg tablet Generic drug: prasugrel	take 1 Tab by mouth Every Day
lisinopril 5 mg tablet Commonly known as: PRINIVIL, ZESTRIL	TAKE ONE-HALF (1/2) TABLET DAILY
METFORMIN PO	take 250-500 mg by mouth daily as needed
*** nitroglycerin 0.4 mg sublingual tablet** Changes: **Another medication with the same name was added. Make sure you understand how and when to take each.** Commonly known as: NITROSTAT	place 0.4 mg under the tongue and let dissolve as needed. (Nitrostat only, do not substitute)

Exhibit 2
Appendix D

Discharge Summary by Rogers, Ian Schirra, MD at 9/4/2015 5:39 PM (continued)

	Instructions
*** nitroglycerin 0.4 mg sublingual tablet** Changes: **You were already taking a medication with the same name, and this prescription was added. Make sure you understand how and when to take each.** Commonly known as: NITROSTAT	place 1 Tab under the tongue and let dissolve as needed for Chest pain (Nitrostat only, do not substitute)

* Notice: This list has 2 medication(s) that are the same as other medications prescribed for you. Read the directions carefully, and ask your doctor or other care provider to review them with you.

Where to Get Your Medications

You need to pick up these prescriptions. We sent them to a specific pharmacy, so go there to get them.

SAFEWAY #25-2719 - 525 EL CAMINO REAL - MENLO PARK, CA - atorvastatin 80 mg tablet - nitroglycerin 0.4 mg sublingual tablet	525 EL CAMINO REAL MENLO PARK CA 94025 Phone: 650-847-2905 Hours: 9AM-8PM M-F, 9AM-5:30PM Sat, 9AM-5:30PM Sun

Discharge Orders/Instructions

Discharge Procedure Orders

Discharge Diet

Order Specific Question	*Answer*	*Comments*
Diet	Diabetic Diet: low carbohydrate, low cholesterol, low saturated fat	

Physical Activity

Order Specific Question	*Answer*	*Comments*
Physicial Activity	As Tolerated	

When To Resume Daily Activities

Notify MD

Order Comments: Warning Signs:

Fever > 100.4 degrees
Night sweats
Chest Pain/ Shortness of breath
Pain uncontrolled by prescribed medications

If you experience these symptoms, please call your primary care providor, Dr. Weinlander, Eva E (General), or reach the hospital team via the pager operator at 650-723-4000. If the symptoms are severe, please go to the nearest emergency

Exhibit 2
Appendix D

Official Copy
Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

Discharge Summary by Rogers, Ian Schirra, MD at 9/4/2015 5:39 PM (continued)

room or dial 911.

You should be contacted for a follow-up appointment. If you do not hear from anyone within the next 3 days, please contact the discharge coordinator Carol at 650-725-6879 to verify your follow-up appointment.

Follow Up (Stanford or UHA)

Dear Mr. Subbiah,

It was a pleasure taking care of you in the hospital. You were hospitalized for chest pain and taken for cardiac catheterization which revealed stenosis of the right coronary artery. A drug eluting stent was placed in this area of stenosis and normal blood flow restored.

There are no changes to you medications.
After discharge, it will be important for you to:

Order Comments:

1. Take all of your medications as prescribed.
2. Follow up with Dr. Fearon (you will receive a call) in 1 month
3. Continue to exercise and eat a diet low in carbohydrates and saturated fats
4. Wait to resume Metformin until Friday 9/4

Sincerely,
Jessica Diane Ferguson, MD

Stanford Inpatient Cardiology

Stanford Hospital and Clinics Appointments Scheduled in the Next 30 Days
No future appointments.

Follow-up appointments to be scheduled: Dr. Fearon in 1 month

This patient was discussed with the attending health care provider: Ian Rogers MD.

Jessica Ferguson, MD
PGY1 - Internal Medicine
Pager: 12814
Date: 9/4/2015

Teaching Physician Attestation
I was present and directly participated during the history and physical examination with the resident/fellow.

I saw and examined the patient and discussed management with the resident/fellow. I reviewed the

Exhibit 2
Appendix D

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 9/1/2015

Discharge Summary by Rogers, Ian Schirra, MD at 9/4/2015 5:39 PM (continued)

resident/fellow's note and agree with the documented findings and plan of care. I confirmed no further chest pain. I confirmed the absence of new murmur on exam. I personally had an extensive discussion with Mr. Subbiah regarding his catheterization findings, the treatment provided, and the risks, benefits, and alternatives of continued medical management. This discussion included consideration of increasing atorvastatin to 80 mg daily vs. change to rosuvastatin given increased risks of side effects with 80 mg atorvastatin. Mr. Subbiah indicated that he preferred increase atorvastatin to 80 mg daily and will review with Dr. Fearon in follow up.

(V) Total attending time for discharge services: 32 minutes, including instructions for follow up and patient and family education.

Ian S. Rogers, MD, MPH, FACC
Clinical Assistant Professor, Cardiovascular Medicine

Electronically signed by Rogers, Ian Schirra, MD at 9/16/2015 10:11 PM

Discharge Summary by Khandelwal, Abha, MD at 10/10/2017 4:26 PM

Author: Khandelwal, Abha, MD	Service: Medicine	Author Type: Physician
Filed: 10/13/2017 9:03 PM	Date of Service: 10/10/2017 4:26 PM	Note Type: Discharge Summary
Status: Addendum	Editor: Khandelwal, Abha, MD (Physician)	

Related Notes: Original Note by Jaluba, Karolina, MD (Resident) filed at 10/13/2017 5:29 PM

Stanford Hospital and Clinics
Discharge Summary

Attending Physician: Khandelwal, Abha MD
Attending Physician Contact Info: 650-723-4000
Additional discharging providers (NP, PA, intern, resident, fellow): Karolina Jaluba MD
Discharging service: Cardiology
Admission Date: 10/9/2017
Discharge Date: 10/10/2017

Principle Diagnosis at Discharge: NSTEMI
Secondary Diagnoses:
Problem List Items Addressed This Visit
Unstable angina (CMS-HCC) - Primary
Relevant Orders
ADMIT TO INPATIENT (Completed)
CONVERT INPATIENT TO OBSERVATION (Completed)
REFERRAL TO CARDIAC REHABILITATION

Other Visit Diagnoses
Acute chest pain

Patient ID: Subramanian Subbiah 10185163

Exhibit 2

Appendix E

Aug / Oct 2016

Exhibit 2, Appendix E

Immunizations

Hep B, adult (Given 11/30/2009, 1/3/2008)
Pneumococcal polysaccharide (PPSV23) (Pneumovax) (Given 10/10/2017, 9/2/2014)
Tdap (> 7 yrs) (Given 12/4/2007)
Typhoid, parenteral (Given 11/30/2009, 1/3/2008, 6/2/2003)
Yellow fever, live (YF-VAX) (Given 11/30/2009)

Implants

Implanted	Type	Area	Manufacturer	Device Identifier	Model / Serial / Lot
Stnt Xience Alpine Rx 2.75x18 - Log673519 Implanted: 10/09/2017 at STANFORD HOSPITAL - IP (Quantity not on file)			ABBOTT VASCULAR DEVICES		1125275-18 / / 7060261

Procedures

ECG 12-Lead (Performed 10/15/2017)
ECG 12-Lead (Performed 10/10/2017)
ECG 12-Lead (Performed 10/9/2017)
ECG 12-Lead (Performed 10/9/2017)
ECHO - Exercise Stress Echo (Performed 10/9/2017)
Performed for Coronary artery disease involving native heart, angina presence unspecified, unspecified vessel or lesion type, Chest pain, unspecified type
CV CATH CORS POSSIBLE (Performed 8/8/2016)
ECG 12-Lead (Performed 8/8/2016)
ECHO - Exercise Stress Echo (Performed 6/28/2016)
Performed for Hyperlipidemia, History of MI (myocardial infarction), History of coronary artery stent placement
CV CATH CORS POSSIBLE (Performed 9/2/2015)
Echo - Transthoracic Echo +Doppler (Performed 9/2/2015)
ECG 12-Lead (Performed 9/2/2015)
ECG 12-Lead (Performed 9/1/2015)
ECG 12-Lead (Performed 9/1/2015)
ECG 12-Lead (Performed 9/1/2015)
ECG 12-Lead (Performed 9/1/2015)
ECG 12-Lead (Performed 4/19/2012)
ECG 12-Lead (Performed 4/18/2012)
ECG 12-Lead (Performed 4/17/2012)
ECG 12-Lead (Performed 4/15/2012)

Third Heart Attack at Stanford August 2016 (Alan Yeung)
↓
October 2016

Am trying to get the detailed paperwork from archives

Results

TSH - Final result (08/22/2020 1:10 PM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
TSH	1.88 Comment: **Clinical consideration: Biotin has been identified by the manufacturer as a potential interfering substance. Higher concentrations of biotin may be found in multivitamins, hair/nail supplements, and workout supplements. If the result does not match clinical observations and patient is taking a supplement containing biotin, repeat testing after patient refrains from the use of supplements for at least 12 hours.**	0.27 - 4.20 uIU/mL	STANFORD HOSPITAL LABORATORY	

This is from the summary screenshot from my Stanford online health portal.

Specimen
Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/ZIP Code	Phone Number
SHC LAB - HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733
STANFORD HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733

Metabolic Panel, Comprehensive (METABOLIC PANEL, COMPREHENSIVE) - Final result (08/22/2020 1:10 PM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Sodium, Ser/Plas	140	135 - 145 mmol/L	STANFORD HOSPITAL	

Exhibit 2

Appendix F

Oct 2017

Exhibit 2
Appendix F

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185183, DOB: 10/29/1961, Sex: M
Adm: 10/15/2017

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

Stanford HEALTH CARE

Emergency Department Provider Note

4th heart attack October 20 17 and complications

Name: Subramanian Subbiah	ED Arrival: 10/15/2017 1:57 PM
MRN: 10185183	Room #: B01

History & Physical

Triage:
Chief Complaint
Patient presents with
- Arm Pain
  s/p stent MI last Monday here, pt with R arm pain due recent access via R forearm. denies CP or SOB, here only for arm.

HPI
55 Y male with hx of coronary cath via right radial artery c/b right arm hematoma who presents with arm pain

Since cath pain improving but continues to experience right arm pain associated with hematoma, some swelling but not worsened since discharge. He denies fevers/chills, no new trauma, no worsening swelling, no numbness or weakness

Expand/ Collapse Notes

History From Shared Lists

Past Medical History:

Diagnosis	Date
•CAD (coronary artery disease)	
•Closed fracture of pelvic rim *MVA*	
•Diabetes mellitus, type 2 (CMS-HCC)	
•Elevated cholesterol	
•H/O colonoscopy with polypectomy *5/2015 ,rpt 5 years, John Selling MD, tubular adenoma, repeat in 5 years.*	5/7/2015
•Hyperlipidemia	
•Malaria *severe, with hepatic involvement*	1988
•MI (myocardial infarction) *s/p DES to LAD*	
•Myocardial infarction	
•PPD positive	1999

No Known Allergies

Prior to Admission Medications

Prescriptions	Last Dose	Information Reported?	Patient Taking?
aspirin 81 mg enteric coated tablet Sig: take 81 mg by mouth daily		Yes	No
atorvastatin (LIPITOR) 80 mg tablet Sig: TAKE 1 TABLET DAILY		No	No
carvedilol (COREG) 3.125 mg tablet Sig: TAKE 1 TABLET TWICE A DAY WITH MEALS		No	No
glipiZIDE (GLUCOTROL) 5 mg tablet		No	No

Exhibit 2
Appendix F

Official Copy
Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185183, DOB: 10/29/1981, Sex: M
Adm: 10/15/2017

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

no INH per pulmonary clinic • Tinea • Vitiligo	Sig: TAKE 1 TABLET TWICE A DAY BEFORE MEALS **lisinopril (PRINIVIL, ZESTRIL) 5 mg tablet** No No Sig: TAKE ONE-HALF (1/2) TABLET DAILY **metFORMIN (GLUCOPHAGE XR) 500 mg TB24** Yes No Sig: take 500 mg by mouth 2 times a day **nitroglycerin (NITROSTAT) 0.4 mg sublingual tablet** No No Sig: place 1 Tab under the tongue and let dissolve as needed Generic ok **prasugrel (EFFIENT) 10 mg TABS** No No Sig: TAKE 1 TABLET DAILY **Facility-Administered Medications: None**

Patient Active Problem List

Diagnosis	Code
• Hyperlipidemia	E78.5
• Malaria	B54
• Vitiligo	L80
• Pelvic fracture (CMS-HCC)	S32.9XXA
• Spinal fracture	IMO0002
• Pain in joint, lower leg	M25.569
• Multiple open pelvic fractures with disruption of pelvic circle (CMS-HCC)	S32.810B
• Keloid scar	L91.0
• Hyperglycemia	R73.9
• Hyperosmolarity due to secondary diabetes (CMS-HCC)	E13.00
• Hypernatremia	E87.0
• H/O colonoscopy with polypectomy	Z98.890, Z86.010
• Diverticulosis of colon (without mention of hemorrhage)	K57.30
• Unstable angina (CMS-HCC)	I20.0
• History of MI (myocardial infarction)	I25.2
• History of coronary artery stent placement	Z95.5
• S/P coronary angiogram	Z98.890
• Uncontrolled type 2 diabetes mellitus with complication (CMS-HCC)	E11.8, E11.65

Past Surgical History:

Procedure	Laterality	Date

Exhibit 2
Appendix F

Official Copy
Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 10/15/2017

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

• CATH CORS POSSIBLE N/A 8/8/2016 *Performed by Yeung, Alan Ching-Yuen, MD at STANFORD HOSPITAL CATH LAB* • CATH CORS POSSIBLE N/A 9/2/2015 *Performed by Yeung, Alan Ching-Yuen, MD at STANFORD HOSPITAL CATH LAB* • COLONOSCOPY DIAGNOSTIC 6/11, 5/2015 *TA, repeat in 5/2020* • HX WISDOM TEETH EXTRACTION 1988 *times 4* No family history on file.		

Social History

Social History • Marital status: Married Spouse name: N/A • Number of children: N/A • Years of education: N/A Social History Main Topics • Smoking status: Never Smoker • Smokeless tobacco: Never Used • Alcohol use No • Drug use: No • Sexual activity: Not on file Other Topics Concern • Not on file Social History Narrative • No narrative on file		

Review of Systems
Constitutional: Negative for chills and fever.
HENT: Negative for congestion, ear discharge, rhinorrhea and sore throat.
Eyes: Negative for pain and redness.
Respiratory: Negative for cough, shortness of breath, wheezing and stridor.

Exhibit 2
Appendix F

Official Copy
Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:6500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 10/15/2017

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

Gastrointestinal: Negative for abdominal distention, abdominal pain, constipation, diarrhea, nausea and vomiting.
Genitourinary: Negative for dysuria and hematuria.
Musculoskeletal: Negative for back pain, neck pain and neck stiffness.
Arm pain and swelling
Skin: Negative for pallor and rash.
Neurological: Negative for dizziness, weakness and headaches.

Physical Exam
Constitutional: He is oriented to person, place, and time. He appears well-developed and well-nourished. No distress.
HENT:
Head: Normocephalic and atraumatic.
Mouth/Throat: Oropharynx is clear and moist.
Eyes: Conjunctivae and EOM are normal. Pupils are equal, round, and reactive to light.
Neck: Normal range of motion. Neck supple. No tracheal deviation present.
Cardiovascular: Normal rate, regular rhythm and normal heart sounds.
Warm distal extrem, normal pulses and cap refill
Pulmonary/Chest: Effort normal and breath sounds normal.
Abdominal: Soft. Bowel sounds are normal. There is no tenderness.
Musculoskeletal: Normal range of motion.
Right arm with hematoma (healing) and mild swelling, no significant erythema, no ttp, no wound noted
Soft compartments in RUE
Neurological: He is alert and oriented to person, place, and time.
Normal sensation throughout all extrem
Skin: Skin is warm and dry.

Procedures

Expand/ Collapse Notes

Labs & Imaging		

ED Physician and Radiology Interpretations:
(For Limited US, complete procedure note)
US UPPER EXTREMITY VEINS DEEP VEIN THROMBOSIS RIGHT
Preliminary Result
IMPRESSION:

1. No ultrasound evidence of deep venous thrombosis.

2. Incidentally noted right forearm subcutaneous hypoechoic mass measuring 0.5 x 2.5 x 1.3 cm, likely

Exhibit 2
Appendix F

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

a benign lipoma.

"This is a preliminary report reviewed by an Attending"

Medical Decision Making

Initial Ddx, assessment and plan:
Likely inadequately controlled pain from hematoma, does have unilateral swelling concerning for DVT. Doubt cellulitis v nec fasc without erythema, warmth, fevers etc.
No signs of compartment syndrome, neurovascular injury
Will get DVT US, pain control

ED Treatment:

Labs ordered:
None

Medications
HYDROcodone-acetaminophen (NORCO) 10-325 mg per tablet 1 Tab (not administered)

Consults ordered:
None

Clinical Decision Rules

ED Course, Data Review & Interpretation:

ED Course as of Oct 15 1646
Sun Oct 15, 2017
1623 US RUE

Impression

IMPRESSION:

1. No ultrasound evidence of deep venous thrombosis.

2. Incidentally noted right forearm subcutaneous hypoechoic mass measuring 0.5 x 2.5 x 1.3 cm, likely a benign lipoma.

Exhibit 2
Appendix F

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 10/9/2017

Discharge Summary by Khandelwal, Abha, MD at 10/10/2017 4:26 PM (continued)

Discharge Orders/Instructions

Discharge Procedure Orders

REFERRAL TO CARDIAC REHABILITATION

Referral Priority: Routine *Referral Type:* Consult, Test & Treat

Referral Reason:
Specialty Services Requested

Discharge Diet

Order Specific Question	*Answer*	*Comments*
Diet	Carbohydrate Controlled	
Can Resume Diet	As Tolerated	

Physical Activity

Order Comments: Please avoid heavy lifting with your right arm for 2 weeks.

Order Specific Question	*Answer*	*Comments*
Physicial Activity	Restricted (see comment)	

When To Resume Daily Activities

Notify MD

Warning Signs: chest pain, shortness of breath, palpitations, fever, chills

Who to call for Concerns:

Order Comments: Clinic: Primary care
Physician: Young, Allen
Daytime phone number: (650)498-6606
After hours number: 650-723-4000 ex27071

Labs Pending At Discharge:
Pending Labs
None

Exhibit 2
Appendix F

Official Copy
Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 10/9/2017

Discharge Summary by Khandelwal, Abha, MD at 10/10/2017 4:26 PM (continued)

If other than home: Name of facility: Not applicable
Emergency Contact: Extended Emergency Contact Information
Primary Emergency Contact: Theresa Cotter
Address: D1 SHC
Home Phone: 650-725-7114
Relation: None

Allergies:
No Known Allergies

Discharge Medications
Consent form attached for all patients on psychoactive medications discharged to SNF

What to do with your medications

TAKE these medications

	Instructions
aspirin 81 mg enteric coated tablet	take 81 mg by mouth daily.
atorvastatin 80 mg tablet Commonly known as: LIPITOR	TAKE 1 TABLET DAILY
carvedilol 3.125 mg tablet Commonly known as: COREG	TAKE 1 TABLET TWICE A DAY WITH MEALS
EFFIENT 10 mg tablet Generic drug: prasugrel	TAKE 1 TABLET DAILY
GLUCOPHAGE XR 500 mg extended release tablet Generic drug: metFORMIN	take 500 mg by mouth 2 times a day
lisinopril 5 mg tablet Commonly known as: PRINIVIL, ZESTRIL	TAKE ONE-HALF (1/2) TABLET DAILY
nitroglycerin 0.4 mg sublingual tablet Commonly known as: NITROSTAT	place 1 Tab under the tongue and let dissolve as needed Generic ok

STOP TAKING these medications

clopidogrel 75 mg tablet
Commonly known as: PLAVIX

Exhibit 2
Appendix F

Discharge Summary by Khandelwal, Abha, MD at 10/10/2017 4:26 PM (continued)

Tricuspid Valve
The tricuspid valve leaflets are thin and pliable and the valve motion is normal. There is trace tricuspid regurgitation.
Aortic Valve
The aortic valve is tri-leaflet. The aortic valve leaflets appear mildly thickened. No aortic regurgitation is present.
Pulmonic Valve
The pulmonic valve leaflets are thin and pliable; valve motion is normal. There is trace pulmonic valvular regurgitation.
Great Vessels
The aortic root is normal.
Pericardium/Pleural
No significant pericardial effusion.

Coronary angiogram 10/9/17:
Procedure Summary
Access:
6FR R Radial
Hemostasis achieved via TR Band

Diagnostic Conclusions:
LMCA- Minor disease
LAD- Patent stents, minor disease
LCx- Patent stents, no significant disease
RCA- 90% mid, patent PDA stent

Interventional Conclusions:
1. Successful PCI to Mid RCA with 2.75 x 18mm Xience drug eluting stent

No complications, EBL minimal
No specimens sent

Recommendations:
1. Aspirin 81 mg once daily indefinitely and Prasugrel 10 mg once daily for 12 months

Complications: None

BEST PRACTICE for patients with AMI or Heart Failure: No applicable diagnoses.
Code status during admission and details of discussions: Full Code
POLST form has been completed if patient discharged to SNF
Overall goals of care for patient's health and functional status: Functionally independent

Caregiver status: self
Cognitive status at time of discharge: alert and oriented
Functional status at time of discharge: Functionally independent
Discharge Diet: Carb controlled

Disposition: Home

Exhibit 2
Appendix F

Discharge Summary by Khandelwal, Abha, MD at 10/10/2017 4:26 PM (continued)

Hospital Course/Significant Findings by Problem:

Problem #1: NSTEMI
History of accelerating angina progressing to angina at rest. Rest Echo showed inferior and posterior WMA. EKG with new LBBB. Found to have elevated troponin. Extensive history of CAD s/p stents to LAD, LCx, Ramus and RCA. Risk factors include age, male gender, +family hx of CAD, HTN, HLD, DM2. Underwent coronary angiogram, which resulted in DES to mid RCA for 90% stenosis. He had right radial site hematoma after cath but improved.
Current Status: Stable
Goals/Plan of care on discharge: **Aspirin 81 mg, Prasugrel 10 mg, Atorvastatin 80 mg. Follow-up with Dr. Alan Yeung in clinic in 1-2 weeks. Recommend to avoid heavy lifting of right arm for 2 weeks.**
Outstanding/pending issues (If/then): none

Problem #2: Hypertension
Current Status: Stable
Goals/Plan of care on discharge: **Carvedilol 3.125 mg BID, Lisinopril 2.5 mg.**
Outstanding/pending issues (If/then): none

Problem #3: HLD
Current Status: Stable
Goals/Plan of care on discharge: **Atorvastatin 80 mg.**
Outstanding/pending issues (If/then): none

Problem #4: DM type II
Current Status: Stable
Goals/Plan of care on discharge: **Metformin 500 mg BID.**
Outstanding/pending issues (If/then): none

Procedures Performed (include dates):
Stress echo 10/9/17:
Interpretation Summary
STRESS ECHO NOT PERFORMED. Drs. Schnittger and Yeung notified. New wall motion abnormality and chest pain at
baseline.
1) Normal LV size with overall moderate reduction in LV systolic function. EF of 42% by MOD. Apical septal, apical, inferior and posterior wall akinesis.
2) Trace MR and TR. RAP of 5 mmHg.
3) Compared to prior stress test on 6/28/16, overall LV function has decreased and new wall motion abnormalities are present in the inferior and posterior walls.
Left Ventricle
The left ventricle is normal in size. There is normal left ventricular wall thickness. The left ventricular ejection fraction is moderately reduced (35-45%). Mitral inflow suggests impaired left ventricular diastolic relaxation. Apical septal akinesis. There is apical akinesis. There is inferior wall akinesis. There is posterior wall akinesis.
Right Ventricle
The right ventricle is normal size. The right ventricular ejection fraction is normal.
Atria
The left atrium is normal size. The right atrium is normal.
Mitral Valve
The mitral valve leaflets appear mildly thickened. There is trace mitral regurgitation.

Exhibit 2
Appendix F

Discharge Summary by Khandelwal, Abha, MD at 10/10/2017 4:26 PM (continued)

Reason for Hospitalization: Subramanian Subbiah is a 55 year old male with history of T2DM, HTN, HLD, known 3V CAD (MI in 2013 s/p DES x2 to ramus intermedius and pCx on 5/15/13) and s/p intracoronary stem cell injection to LAD (6/5/13) with UA s/p DES to RCA (9/1/15) with rest echo with inferior and posterior WMA.

Brief History of present illness:

From H&P:

"Patient reports worsening chest pain that started 10-20 days ago. Describes pain as left-sided, pressure-like, radiating to left arm. The pain has been increasing in severity and frequency over the last few days. The pain was initially present with exertion and progressed to pain at rest. Denies dyspnea, v/d, f/c, palpitations, diaphoresis, LEE, orthopnea.

Patient follows with Dr. Alan Yeung. He went for stress Echo today, results of resting Echo showed inferior and posterior WMA and patient was sent immediately to the emergency room.

Cardiac hx:
05/2013: DES to LCx/OM1 and ramus, LAD
09/2015: DES to distal RCA (with 30% residual stenosis) and rPDA (50% ISR in prox-mid LAD stent)
08/2016: Patent stents in the LAD, LCx, ramus intermedius, and RCA. 50% in-stent restenosis of the LAD stent. No significant change from previous angiogram on 9/2/2015.

ED Course:
- AF, HR 64, BP 112/81, RR 23, 97 on RA
- trop 0.615, EKG with new LBBB
- CXR nl, CBC and CMP wnl
- started on heparin gtt, ASA/Atorva/Prasugrel
- nitro SL

PMH:
CAD s/p multiple stents
HTN
HLD
D2M
Vitiligo

Medications:
Aspirin 81 mg
Prasugrel 10 mg
Atorvastatin 80 mg
Carvedilol 3.125 mg BID
Lisinopril 2.5 mg
Metformin 250 mg BID
Glipizide 5 mg BID

Family hx:
Extensive history of CAD in multiple family members"

Exhibit 2
Appendix F

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 10/15/2017

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

	and discussed management with the resident. I reviewed the resident note and agree with the documented findings and plan of care.
Ultrasounds & Procedures:	No Procedure
Critical Care:	Not applicable

Electronically signed by Acker, Peter Corrigan, MD at 10/15/2017 11:14 PM

Scan on 2/19/2020 6:15 PM by Lopez, Lucie (below)

Exhibit 2
Appendix F

Official Copy

Stanford HEALTH CARE
STANFORD MEDICINE

STANFORD HOSPITAL - IP
300 PASTEUR DRIVE
MC:5500
Stanford CA 94305-2200

Subbiah, Subramanian
MRN: 10185163, DOB: 10/29/1961, Sex: M
Adm: 10/15/2017

ED Provider Notes by Acker, Peter Corrigan, MD at 10/15/2017 4:46 PM (continued)

(CD)

ED Course User Index
(CD) Dart, Casey Dixon, MD

ECG at 1411 showing NAR rate in 70's, left axis, normal segments, TWI in III, AVF, V1, biphasic in v4-v5. Compared to prior from 10-10-17, improved, lbbb.

Summary of assessment:
55 year old s/p coronary cath c/b right arm hematoma who presents with persistent arm pain. DVT us neg for clot. Pain controlled, discharged with pain meds. Strict return precautions discussed.

Disposition:
(Refresh before signing)
Diagnosis: Traumatic hematoma of right upper arm, initial encounter
Disposition: Data Unavailable
Admitting Attending: No admitting provider for patient encounter.
OR
Follow up: Young, Allen, MD
General Surgery
300 Pasteur Dr Rm H3591
MC 5641
Stanford CA 94305
(650)498-6606

In 2 days

Emergency Department
300 Pasteur Drive
Stanford California 94305
650-725-4492

As needed, If symptoms worsen

HYDROCODONE-ACETAMINOPHEN (NORCO) 5-325 MG TABLET	take 1 Tab by mouth every 4 hours as needed for Pain

Resident: Casey Dixon Dart, MD
Attending: Peter Corrigan Acker, MD

Expand/ Collapse Notes

Attending Attestions
Supervision: Resident Attestation: I saw and examined the patient

Exhibit 2
Appendix F

			HOSPITAL LABORATORY
MCHC	34.4	32.0 - 36.0 g/dL	STANFORD HOSPITAL LABORATORY
RDW	13.6	11.5 - 14.5 %	STANFORD HOSPITAL LABORATORY
Platelet count	185	150 - 400 K/uL	STANFORD HOSPITAL LABORATORY

Specimen

Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/ZIP Code	Phone Number
SHC LAB - HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733
STANFORD HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733

ECG 12-Lead (ECG 12-LEAD) - Final result (10/10/2017 12:29 AM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Heart Rate	62	bpm	TRACEMASTER VU LAB	
RR	968	ms	TRACEMASTER VU LAB	
P-R Interval	153	ms	TRACEMASTER VU LAB	
QRSD Interval	165	ms	TRACEMASTER VU LAB	
QT Interval	422	ms	TRACEMASTER VU LAB	
QTC Interval	427	ms	TRACEMASTER VU LAB	
P Axis	64	degrees	TRACEMASTER VU LAB	
QRS Axis	-53	degrees	TRACEMASTER VU LAB	
T Wave Axis	82	degrees	TRACEMASTER VU LAB	
ECG Impression	- ABNORMAL ECG - Sinus rhythm Left bundle branch block NO SIGNIFICANT CHANGE SINCE THE PREVIOUS RECORD		TRACEMASTER VU LAB	

Specimen

Performing Organization	Address	City/State/ZIP Code	Phone Number
IECG LAB	Stanford Hospitals	Palo Alto, CA 94002	
TRACEMASTER VU LAB	Stanford Hospitals	Palo Alto, CA 94002	

CV CATH PROCEDURE - Final result (10/09/2017 6:29 PM PDT)

4th heart attack

Specimen

Performing Organization	Address	City/State/ZIP Code	Phone Number
CATH ANGIO LAB	300 Pasteur Drive	Stanford, CA 94305	650-723-7676

Exhibit 2 Appendix F

STOOL - OCCULT BLOOD EXAM (OCCULT BLOOD EXAM (GUIAC PERFORMED)) - Final result (10/09/2017 2:58 PM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Occult blood, stool	Negative	Negative		
QC Result	Passed			
Hemoccult Lot#	107113R			
Hemoccult Exp Date	7/20			
Developer Lot#	65923h			
Developer Exp Date	10/20			

Specimen

Stool

~~ECG~~ 12-Lead (ECG 12-LEAD) - Final result (10/09/2017 1:55 PM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
~~Heart Rate~~	64	bpm	TRACEMASTER VU LAB	
RR	938	ms	TRACEMASTER VU LAB	
P-R Interval	165	ms	TRACEMASTER VU LAB	
QRSD Interval	169	ms	TRACEMASTER VU LAB	
QT Interval	441	ms	TRACEMASTER VU LAB	
QTC Interval	451	ms	TRACEMASTER VU LAB	
P Axis	42	degrees	TRACEMASTER VU LAB	
QRS Axis	-38	degrees	TRACEMASTER VU LAB	
T Wave Axis	84	degrees	TRACEMASTER VU LAB	
ECG Impression	- ABNORMAL ECG - Sinus rhythm Left bundle branch block NO SIGNIFICANT CHANGE SINCE THE PREVIOUS RECORD I have personally reviewed the test result and agree with the interpretation above.		TRACEMASTER VU LAB	

4m attach

Specimen

Performing Organization	Address	City/State/ZIP Code	Phone Number
IECG LAB	Stanford Hospitals	Palo Alto, CA 94002	
TRACEMASTER VU LAB	Stanford Hospitals	Palo Alto, CA 94002	

XR Chest 1 View (XR CHEST 1 VIEW) - Final result (10/09/2017 1:19 PM PDT)

Specimen

Impressions	Performed At
IMPRESSION:	RADIOLOGY
1. No acute cardiopulmonary disease.	

"Physician to Physician Radiology Consult Line: (650) 736-1173"

Signed

Exhibit 2
Appendix F

			HOSPITAL LABORATORY
MCHC	34.6	32.0 - 36.0 g/dL	STANFORD HOSPITAL LABORATORY
RDW	13.6	11.5 - 14.5 %	STANFORD HOSPITAL LABORATORY
Platelet count	223	150 - 400 K/uL	STANFORD HOSPITAL LABORATORY
Neutrophil %	48.0	%	STANFORD HOSPITAL LABORATORY
Lymphocyte %	40.4	%	STANFORD HOSPITAL LABORATORY
Monocyte %	7.4	%	STANFORD HOSPITAL LABORATORY
Eosinophil %	3.7	%	STANFORD HOSPITAL LABORATORY
Basophil %	0.5	%	STANFORD HOSPITAL LABORATORY
Neutrophil, Absolute	4.61	1.70 - 6.70 K/uL	STANFORD HOSPITAL LABORATORY
Lymphocyte, Absolute	3.88	1.00 - 3.00 K/uL	STANFORD HOSPITAL LABORATORY
Monocyte, Absolute	0.71	0.30 - 0.95 K/uL	STANFORD HOSPITAL LABORATORY
Eosinophil, Absolute	0.36	0.05 - 0.55 K/uL	STANFORD HOSPITAL LABORATORY
Basophil, Absolute	0.04	0.00 - 0.25 K/uL	STANFORD HOSPITAL LABORATORY

Specimen

Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/ZIP Code	Phone Number
SHC LAB - HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733
STANFORD HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733

4th heart attack

Troponin I (TROPONIN I) - Edited Result - FINAL (10/09/2017 12:53 PM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
TROPONIN I	0.615 Comment: POSITIVE, above the 99th percentile. New method and reference ranges, effective April 3, 2017. Biotin has been identified by the manufacturer as a potential interfering substance. Higher concentrations of biotin may be found in multivitamins, hair/nail	<0.055 ng/mL	STANFORD HOSPITAL LABORATORY	

Exhibit 2
Appendix F

supplements and workout supplements. If the result does not match clinical observations, repeat testing after patient refrains from the use of supplements for at least 12 hours.
CALLED READ BACK BY: LISA DUFFY RN
occurred: 10/9/2017 2:39 PM by
DOLE, DIANA

Specimen

Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/ZIP Code	Phone Number
SHC LAB - HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733
STANFORD HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733

PTT Partial Thromboplastin Time (PTT PARTIAL THROMBOPLASTIN TIME) - Final result (10/09/2017 12:53 PM PDT)

Component	Value	Ref Range	Performed At	Pathologist Signature
Part. Thromboplastin Time	24.7 Comment:	23.8 - 35.7 seconds	STANFORD HOSPITAL LABORATORY	

Note regarding heparin monitoring:
Traditionally, a PTT of 1.5-2.5 times control value has been used for heparin monitoring. However, heparin effects on PTT are variable between individuals and reagent/instrument combinations.

Thus, for heparin monitoring, heparin activity level (HAL) in anti-Xa U/mL is recommended. The therapeutic range for heparin therapy of venous thrombembolic disease is 0.3 - 0.7 anti-Xa U/mL (the recommended range can vary with the indication for heparin therapy - see heparin protocols for suggested ranges).

For reference, therapeutic range from 0.3 - 0.7 anti-Xa U/mL corresponds to a PTT of 78 - 121 seconds in the Stanford coagulation laboratory using a Stago STA-R automated instrument and PTT-automate reagent.
New Ref Range in use 8/1/2016

Specimen

Blood - Blood specimen (specimen)

Performing Organization	Address	City/State/ZIP Code	Phone Number
SHC LAB - HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733
STANFORD HOSPITAL LABORATORY	300 Pasteur Drive	STANFORD, CA 94305	877-717-3733

Prothrombin Time (PROTHROMBIN TIME) - Final result (10/09/2017 12:53 PM PDT)